Do Personnel with Lived Experience Cultivate Public Values? Insights and Lessons from Mental Health Care Managers

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Abstract

Health care organizations charged with addressing public problems sometimes employ persons with relevant lived experience in meaningful organizational roles. Because of their prior experience living with the challenges their facilities are charged with addressing, these individuals have intimate knowledge of the subject matter that professional training and education cannot replicate. Mental health treatment facilities in particular have demonstrated a growing trend toward incorporating staff members with lived experience. This study conducted semi-structured interviews with senior-level managers of organizations in this field to gain insight into the public values associated with this practice. Findings reveal that several public values, including dialogue, social cohesion, sustainability, productivity, and altruism, are cultivated when treatment facilities incorporate staff members with lived experience into service delivery. This study concludes with lessons for mental health care managers seeking to innovatively address mental illness.

Introduction

Mental health and substance abuse treatment facilities provide treatment and recovery support for individuals coping with behavioral health illnesses, such as addiction and drug abuse, serious emotional disturbance, and depression. This is a social services domain that deals almost exclusively with *adaptive challenges*, or problems "not amenable to authoritative expertise and standard operating procedures. [These challenges] cannot be solved by someone who provides answers from on high."[1(p13)] In light of this reality, and in response to demands for patient empowerment, inclusivity, and a culturally competent workforce that understands the needs of the target population,[2] mental health organizations have pioneered efforts to incorporate staff members with lived experience into recovery models, treatment plans, and other features of

policy implementation.[3] Doing so enables individuals to leverage their lived experience as former recipients of services as a resource that qualifies them to engage in both providing client care and educating other mental health professionals.[4,5] Their organizations focus on these staff members' assets and strengths rather than on their prior illnesses.[6-8]

Public values such as social cohesion or sustainability are widely agreed-upon societal values that health care organizations seek to advance together with the individual outcomes they focus on for their clients. Despite growing knowledge of the benefits to client outcomes of integrating persons with lived experience into mental health treatment, research is silent on which broader public values may be associated with this service-delivery model and how. This study aims to fill this gap in knowledge by conducting semi-structured interviews with 26 senior-level managers of government, private, and nonprofit mental health treatment facilities.

For mental health treatment facilities, a public values framework might provide (1) internal stakeholders with insight into the organizational utility of a service-delivery model which integrates personnel with lived experience, (2) specific terminology managers can use when communicating to external stakeholders how personnel with lived experience may help further the public good, and (3) a prism through which personnel with lived experience can understand the value they bring to organizations.

Personnel with Lived Experience in the Mental Health Treatment System

In mental health service organizations, including personnel with lived experience "in matters as diverse as service delivery, policy formation, participation in interview panels, and the development of new models of care has evolved from its somewhat tokenistic foundations to become an expectation."[5(p196)] According to Mowbray and colleagues, "hiring consumers as

providers reflects a recognition that professionally credentialed and formally trained human service professionals cannot meet all of the needs of people with serious mental illness and that consumers themselves bring something distinctive to the service process"[9(p397)].

Dubin-McKnight maintains that "the involvement of peer-employees in traditional mental health systems increases positive outcomes for recipients of services because of the peer-employee's receptiveness and efforts made to reduce the power imbalances inherent in service provision"[10(p24)]. A facility that integrates personnel with lived experience can decrease the level of medication consumed and accelerate recovery,[11] reduce hospitalization,[12,13] improve satisfaction with care,[14,15] increase quality of life,[15-17] improve medication compliance and engagement in treatment,[15,17] and elevate community involvement.[18] However, despite the reported benefits, there are also challenges and barriers to integrating staff members with lived experience. Peer support providers with lived experience may face resistance from clinical staff[19]; struggle with boundaries, such as client confidentiality[16,20]; and trigger concerns about tokenism.[8]

Public Values and the Mental Health Treatment System

Public values are values to which citizens should be entitled and the principles on which government and public policies should be based.[21] Public values are advanced not through the government sector alone, but also through private and nonprofit organizations.[22, 23, 24] In the mental health treatment system, public values are advanced when either the public or private sector provides goods and services to address adaptive challenges specific to this domain, such as addiction and drug abuse, serious emotional disturbance, and depression. Innovative approaches to service delivery, such as integrating staff with lived experience, are necessary to advancing outcomes at both client and organizational levels and the public values therein.

Methodology

This study draws on the insights and attitudes of senior-level managers through semi-structured interviews.[*] We describe the case selection, data collection, and data analysis procedures below, all of which are part of a larger ongoing study of the design and management of facilities in the mental health treatment system.

Case Selection

We began by accessing a list of the organizations included in the Mental Health Treatment Facility Locator ("Locator") online repository supported by the Substance Abuse and Mental Health Services Administration, an agency within the US Department of Health and Human Services. From this list, we contacted facility managers one by one through e-mail and inquired about their willingness to participate in a telephone interview. To those who were willing, we sent a formal invitation that included the background and objectives of the study, consent processes, and confidentiality. We solicited participants from the US Midwest and sought to obtain a heterogeneous purposive sample of informants in categories such as sector affiliation, gender, and organizational size.

A total of 26 senior-level managers of treatment facilities (e.g., president and CEO, chief operating officer) participated in in-depth interviews over a 7-month span. Our sample size of 26 participants is consistent with the guidelines of studies prescribing appropriate sample sizes for qualitative research requiring interviews. [27-29] The Table describes the sample.

[Table about here]

[*] Managers' perceptions were influenced by other people in their organizations who had lived experience. The managers themselves did not have relevant lived experience as described here.

Data Collection

We collected data through open-ended, semi-structured telephone interviews. In the first phase, we interviewed 16 managers from January to March 2017. The second phase of interviews, from June to August 2017, included 10 additional managers. The period between the two phases provided time for the research team to process the initial interview data. We were more targeted during the second phase of interviews as we aimed to confirm emerging public values themes that surfaced during the first phase of interviews. The semi-structured interview format allowed us to explore questions during the second phase of interviews that were raised during the first phase, such as how managers defined the public values they identified.

Interview questions were designed to elicit information about how integrating persons with lived experience affected an organization's efforts to advance public values. To begin, we asked managers to identify their facilities' performance objectives. We then asked them to identify organizational and environmental mechanisms that facilitated or constrained their facilities' ability to achieve these objectives. Next, we asked if their facilities had ever formally utilized (e.g., hired, appointed) former clients or other persons with lived experience to design, implement, and/or evaluate organizational services; if yes, we asked managers to explain these individuals' specific roles and their impact on the organization's performance objectives. Where applicable, we subsequently asked managers to specifically identify the impact of employees with lived experience on the organization at large, on current clients, and on professional staff who did not have lived experience. Managers who said their facilities did not employ personnel with lived experience were asked to theorize on the impact these individuals might have on their facilities.

Data Analysis

For the first phase of interviews, two researchers participated in a process of open coding to identify and categorize patterns emerging from the data. We aimed to identify common codes from manager responses and subsequently aggregate these codes into primary dimensions based on thematic relationships with public values, which were identified deductively from theory and previous literature (e.g., Jorgensen and Bozeman[23]). After conducting these coding steps independently, we pursued inter-coder reliability by comparing the coding patterns and public values themes that emerged and engaging in thorough discussions to resolve discrepancies. Data analysis procedures for the second phase of interviews mirrored those of the first phase but occurred after we had developed preliminary findings. This process ultimately yielded agreement on the primary public values that informants identified as being associated with organizational inclusion of personnel with lived experience.

Findings

Nearly two-thirds of those interviewed had personnel with lived experience integrated into their organizations on a formal basis, albeit at varying levels. Such personnel occupied internal nonclinical roles, filled clinical roles in which they worked alongside licensed physicians, engaged in external outreach, and served on governance bodies such as boards of directors. Findings revealed that managers associated the integration of persons with lived experience with 5 public values: dialogue, social cohesion, sustainability, altruism, and productivity. They identified advancement of these values in their mental health treatment facilities' inputs, processes, and outputs, all of which were expected to contribute to desired client and organizational outcomes.

Dialogue, as a public value, centers on processes that enable mental health treatment facilities to gain insight into clients' points of view; openness to these points of view is a precondition to dialogue.[23] Persons with lived experience enhanced dialogue between service providers and clients by gaining client trust based on common experiences. According to managers, individuals with lived experience did so at a quicker rate and on a deeper level compared to their colleagues who did not have lived experience. One manager remarked,

> I remember one [time] where one of our staff had a peer worker go with her to visit someone who was in a state hospital, and it was someone that [our employee] just couldn't engage. So our peer worker goes with her and, all of a sudden, there is this conversation that is just so productive and informative that never before [occurred]. Trust just came immediately . . . If they're talking to a psychologist, for example, [clients question] 'How can you know my life, in my world?' But if you're talking with someone who is a peer, those trust barriers are broken immediately. We've just seen it over and over.

Social cohesion is a value that advances the idea that society is not divided up into subcultures, but certain bonds unite us all.[23] Patient recovery from mental illness does not follow from authoritative expertise alone,[1(p13)] and managers found that persons with lived experience helped remove the potentially deleterious social silos between clinicians and clients. According to one manager,

> It's easy to get in an 'us and them' attitude with my staff and the clients . . . We know now, and have known for some time, that that's not how it works at all . . . Having people with lived experience who are willing to talk about that openly reminds everyone of that truth and reality . . . It just changes the dynamics; it's an evolution away from the medical model and more toward a recovery model where we really see these people as experts.

The value of sustainability is seen in facility activities that pursue a core objective to advance *long-term* human needs.[23] According to managers, integrating personnel with lived experience promoted clients' long-term mental health needs, including needs that extended beyond clinical considerations. For example, peer support in the form of an employment coach

helped advise clients on obtaining and *maintaining* steady employment during and following clinical treatment. Offering peer support, often at the very facilities where they received treatment, also helped persons with lived experience sustain their own mental health. Speaking specifically to this issue, a manager commented,

> If someone has a sustainable recovery and is working their program, or whatever that looks like as far as maintaining their recovery and their mental health, then it's been rewarding for them to be here.

Productivity is a value that implies effectiveness, specifically "a concern with the quality of the output measured against some standard."[25(p90)] It requires managers to answer the question "Are we accomplishing the goal we set out to accomplish?" [25(p90)] Managers found that persons with lived experience fostered productivity and helped treatment facilities meet their core objectives at both the client and organizational levels. One manager noted,

> Having persons with lived experience is something that I believe is critically important in terms of really getting to a real understanding of how to make sure your customer service is strong and making sure that your program design and operations are clear and are client-friendly, client-centered. It keeps leadership at all levels very grounded into the day-to-day operations of how to provide good patient-centered care.

Lastly, altruism is a value that refers to acting in the interest of others: it "add[s] a form of human authenticity to the creation of the common good and contribute[s] to the public good."[23] Persons with lived experience promoted altruism not simply by serving in peer-support roles, but by the selfless manner in which they serve. In fact, one manager suggested that the basic premise of the 12-step model associated with drug rehab points directly to altruism, specifically service consumers "helping others achieve and maintain abstinence from the substance or behaviors to which they are addicted."[26] This manager remarked,

> It helps the new clients that [integrating persons with lived experience] is kind of the philosophy of working a 12-step program . . . In the 12 steps is [giving] back freely to

> others as others have given to you. So you benefit by helping others to get you out of yourself and [it] helps you to realize there's more to your recovery process than just being very self-centered.

Conclusions: Lessons for Mental Health Care Managers

Several key lessons for managers of mental health care organizations emerge from this study. First, better understanding the public values associated with the organizational contributions of persons with lived experience might help managers more intentionally integrate these individuals within their treatment facilities, with special attention to specific roles and levels of engagement. For example, if an aspect of a mental health treatment facility's services requires enhanced dialogue, managers might consider incorporating persons with lived experience in ways that specifically foster communicatory exchanges between service providers and current and prospective clients. Second, managers must secure buy-in of this service-delivery model—and the public values their organizations aim to cultivate through this model—from stakeholders at all levels of the organization, namely front-line employees such as clinicians who have direct contact with clients. Third, managers must create organizational institutions and processes (e.g., education/training, monitoring, boundary setting) to support this service-delivery model, particularly those which address the learning curve that clinical and administrative staff will experience when working with personnel with lived experience and help the organization avoid undermining existing clinical and administrative strengths. For example, some managers recommend creating organizational units or divisions specifically designed to support this service-delivery model (e.g., a Department of Peer Recovery Specialists).

Integrating persons with lived experience, however, may not be helpful to every organization. Managers in this study who were aware of the practice suggested several reasons that their facilities did not do so. Specific organizational objectives, structure, or size might increase the potential costs or reduce the expected benefits. Lack of resources and potential legal

considerations were other reasons cited for a facility choosing not to integrate persons with lived experience.

Given that study participants were mainly in support of a service-delivery model which integrates personnel with lived experience, a potentially richer analysis might result from interviews with managers (particularly those whose organizations did not adopt this service-delivery model) to identify any public values they perceive as being threatened by this model. Nonetheless, the opportunities and challenges associated with integrating persons with lived experience, including the implications for the organization's ability to cultivate public values, merit attention from managers of public and private mental health care treatment facilities.

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Table

Respondent Characteristics

Respondent	*Sector*	*Gender*	*Years in Management Role*	*No. of FTE Employees in Organization*	*Presence of Organization-Designed Roles for Persons with Lived Experience*
1	Nonprofit	Male	40	183	Yes
2	Nonprofit	Female	10	810	Yes
3	Government	Female	0.5	44	Yes
4	Nonprofit	Female	24	382	Yes
5	Nonprofit	Female	15	75	Yes
6	Nonprofit	Female	7	800	Yes
7	Nonprofit	Male	17	400	Yes
8	Government	Male	0.5	41	Yes
9	Government	Male	10	624	No
10	Government	Female	10	18	No
11	Nonprofit	Male	1	1,129	Yes
12	Government	Female	15	42	No
13	For-profit	Male	8	5	No
14	For-profit	Female	1.5	5	No
15	For-profit	Male	18	1,600	Yes
16	For-profit	Male	1	8	Yes
17	Nonprofit	Female	6	275	Yes
18	For-profit	Female	8	7	Yes

19	Nonprofit	Female	15	42	No
20	Nonprofit	Male	3.5	230	Yes
21	Government	Male	4	12	Yes
22	Government	Female	11	34	No
23	For-profit	Female	1	23	Yes
24	Nonprofit	Male	1	450	Yes
25	Government	Male	3	13	No
26	For-profit	Female	9	37	No